# STATE OF MARYLAND—CERTIFICATE OF DEATH

09734

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH** 14-C

County Prince Georg's Registration Dist. No. 242

Village or City Hall, Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** Elsie Mumford Arnold If U. S. Veteran, specify WAR

(a) Residence: No. Hall, Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Female | White | Married |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Daniel Arnold

6. DATE OF BIRTH (month, day, and year) Jan 24 1911

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 29 | 7 | 29 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Capitol Heights Md (State or country)

FATHER

13. NAME Oakley

14. BIRTHPLACE (city or town) England (State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) England (State or country)

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Holy Trinity Date Sept 25, 1940

19. UNDERTAKER M. Fleming Sons (Address) Bowie Md

20. FILED 9/26/40, 19 W. L. Tritt Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** September (Month) 23 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1940, to Sept 23, 1940

I last saw h alive on Sept 23, 1940; death is said to have occurred on the date stated above, at 2:05 P.M.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Postpartum Hemorrhage | 1940 |
| | |
| | |
| | |
| Other **Contributory Causes** of Importance: | |
| Hemolysis Anemia | 1940 |
| | |

Neme of operetion None Date of —

What test confirmed diagnosis? None Wes there en autopsy? No

23. If death wes due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? No Date of injury, 19

Where did injury occur? None (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury None

Nature of injury —

24. Was disease or injury in any way related to occupetion of deceased?

If so, specify

(Signed) Jerry P. Passano M. D.

(Address) Upper Marlboro, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

Dr. A. Mazuchow MacDonald - Washington - Coroner released body.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

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OCT 3 1930
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09735

Reg. Dist. No. 243

**1. PLACE OF DEATH:**

County: Prince Georges

City or town: Glen Dale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 5 mos

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1419 Columbia Rd N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

**3.(a) FULL NAME:** Dellie Louise Aughinbaugh

**3.(b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 11, 1921

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 6 | 11 | ..... hrs. ..... min. |

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER — 12. Name: Edw H. Aughinbaugh

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Margaret E. Foley

15. Birthplace: Virginia

16. Informant: Deceased

Address: 1419 Columbia Rd N W

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 9-22-40 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D C.

18. Funeral director: S. H. Weiss and Co.

Address: 2901 - 14 St. N.W.

19. 9-22- 1940 (Date rec'd by registrar) Leo V. Kilmide M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 22nd 1940, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22nd 1940 to Sept 22 1940

and that I last saw h.. alive on Sept 22nd 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 5 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: 9-22-40

Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-16)

09736

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Prince George

City or town: Seabrook Md. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Home

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Seabrook, Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mildred Baker

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | ~~Married~~ widowed |

6 (b) Name of husband or wife: Arthur Baker

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 3, 1882.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 8 | 17 | hrs. min. |

9. Birthplace: New York City (Town, county, and state)

10. Usual occupation: H. W.

11. Industry or business: —

FATHER — 12. Name: Gustav Farber

FATHER — 13. Birthplace: Germany.

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: ?

18. Informant: Arthur Baker

Address: Seabrook md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-40 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Colmar Manor Md.

18. Funeral director: W. W. Chambers Co

Address: 918 Cleveland Ave Riverdale Md

19. Sept. 23 1940 (Date rec'd by registrar) J. Wm. Wright. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-20 1940

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-3 1940, to 9-20 1940, and that I last saw h alive on 9-20 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma | 2 Mo. |
| Epitheliod Cavity | |
| Primary Origin | |
| Due to unknown | |
| no more obtainable Cause of | |
| Due to Toxic Emaciation | 9-17-40 |
| Other conditions Acute Cardiac | |
| Dilatation | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: B Rubin M. D. or other

Address: Laurel Date signed June

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OCT 7 1940
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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09737

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Prince Georges County
City or town: Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 23 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 8 months, 23 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1761 Lyman Pl, N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

**3.(a) FULL NAME:** John W Barton

**3.(b) Social Security Number:** 195058207

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Beulah Barton
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): December 1, 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 29 | 9 | 4 | ...hrs. ...min. |

9. Birthplace: Plaquemine, Louisiana (Town, county, and state)
10. Usual occupation: Iron Worker
11. Industry or business: Iron Industry
FATHER 12. Name: Aid Wesley Barton
FATHER 13. Birthplace: Texas
MOTHER 14. Maiden name: Katie Bowers
MOTHER 15. Birthplace: Plaquemine, Louisiana
16. Informant: Deceased
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 6 1940 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.
18. Funeral director: W. W. Chambers Co.
Address: 3072 M. St. N.W. Wash., D.C.
19. Sept 6 1940 (Date rec'd by registrar) Leo V. Altmeyer M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1940, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1940 to Sept 5 1940 and that I last saw h.l.m. alive on Sept 5 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary tuberculosis | one year and 11 months |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Pincare M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed
Glenn Dale Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09738

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A13

**1. PLACE OF DEATH:**
County: Prince Georges
City or town: Glenn Dale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos
Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 7 mos.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 905 - O ST N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

**3.(a) FULL NAME:** Chas. Benjamain

**3.(b) Social Security Number:** 579-05-7644

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | Colored | Separated |

6.(b) Name of husband or wife: not given

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 1st 1910

8. AGE: Years: 30 | Months: 4 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Florence S C (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Frank Benjamain
13. Birthplace: S.C

MOTHER
14. Maiden name: Lenora —
15. Birthplace: Florence S.C.

16. Informant: Deceased
Address: 905 - O ST NW

17. Burial, cremation, or removal. Which?: Removal to
Date thereof: 9/15/40 (month) (day) (year)

Cemetery or crematory:
Location: Washington, D.C.

18. Funeral director: Robinson Com. Undertaker
Address: 1342 - 4th St. N.W.

19. Sept 15 1940 (Date rec'd by registrar)
Leo V. Allwein M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12th 1940 at 4 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 5th 1940, to Sept 12th 1940
and that I last saw him alive on Sept 12, 40 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 1 yr 3 mos |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy with in 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed: 9/12/40

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OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

# CERTIFICATE OF DEATH

09739

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Prince George Co.
City or town: Open Hill md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Pr. George
City or town: Open Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Frances Berry.

**3. (b) Social Security Number:** None

**4. Sex:** Female

**5. Color or race:** white

**6. (a) Single, married, widowed, or divorced:** Widowed

6 (b) Name of husband or wife: Charles H. Berry

6(c) If alive, give age: years

**7. Birth date of deceased (mo., day, yr.):** Sept. 4 - 1854

**8. AGE:** Years: 86 | Months: | Days: 17 | If less than one day: hrs. min.

**9. Birthplace:** Hyattsville Prince Geo.
(Town, county, and state)

**10. Usual occupation:** housewife

**11. Industry or business:**

FATHER
**12. Name:** Edmond Talbert
**13. Birthplace:**

MOTHER
**14. Maiden name:**
**15. Birthplace:**

**16. Informant:** Edith M. Seitz
Address: Open Hill. Md

**17.** burial (Burial, cremation, or removal. Which?) Date thereof 9/23/40 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Md.

**18. Funeral director:** Wm. J. Malley Inc.
Address: 522 - 8th St. S.E.

**19.** Sept. 21 1940 (Date rec'd by registrar) M. Richardson Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH:** September 21 1940, at M

**21.** I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 18 1940, to Sept 21 1940, and that I last saw h alive on Sept 16 1940 18

Immediate cause of death: Uro-Cardiac Failure
(a) ; duration, five years. Q.W.S.R.

DURATION

Due to: Senility & Hardening

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

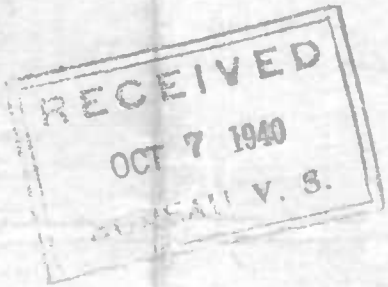
Major findings:
Of operations: X
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

**23. SIGNATURE:** W. A. Bull M. D. or other
Address: 428 - 5th St. Date signed: 9-21-40

Authorization to add date of death, letter in
Permanent File under M. L. Richardson, Registrar. 10-16-40.
C.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09749

Reg. Dist. No. 243

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**

County: Prince Georges

City or town: Glenn Dale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days.

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 14 days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 490 Savoy Court S.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

**3.(a) FULL NAME** Charles Boyd

**3.(b) Social Security Number** 577-12-6086

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6.(b) Name of husband or wife: Ellean Boyd

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 11 | 29 | ...hrs. ...min. |

9. Birthplace: Newberry Co., S.C. (Town, county, and state)

10. Usual occupation: Pipe Layer

11. Industry or business: W.P.A.

FATHER 12. Name: Charles Young

13. Birthplace: S.C.

MOTHER 14. Maiden name: Maggie Boyd

15. Birthplace: S.C.

16. Informant: Deceased

Address: 490 Savoy Court S.W. Wash. D.C.

17. Removed to (Burial, cremation, or removal. Which?) Date thereof: Sept 24 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: Robinson & Co.

Address: 1342 - 4½ St. N.W. Wash. D.C.

19. Sept 24 1940 (Date rec'd by registrar) Le V. Schneider M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 23 1940, at 12 40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9, 1940, to Sept. 23 1940

and that I last saw h... alive on ... 19...

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 3 mos.

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: Glenn Dale, Md.

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09741
Reg. Dist. No. 243

**1. PLACE OF DEATH:**
County: Prince Georges
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium, Glenn Dale, Md.
How long in hospital or institution? 5 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 520 Harvard St, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

**3. (a) FULL NAME** Laura Broadmax

**3. (b) Social Security Number** None

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): June 26, 1916

**8. AGE:** Years 24 | Months 2 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace: New York
(Town, county, and state)
10. Usual occupation: General Housework
11. Industry or business:
FATHER
12. Name: Luke Broadmax
13. Birthplace: North Carolina
MOTHER
14. Maiden name: Lorna Bird
15. Birthplace: North Carolina
16. Informant: —
Address: —
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 7 1940 (month) (day) (year)
Cemetery or crematory: Broadnax Cemetery
Location: North Hampton County, North Carolina
19. Funeral director: W.C. Williams
Address: Rosinah Springs N.C.
19. Sept. 6, 1940 (Date rec'd by registrar) Leo V. Almeida M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1940, at 12:02 P.M. EST
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1940, to Sept. 5 1940 and that I last saw her alive on Sept. 5 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary tuberculosis | 5 mo. |
| Due to Tubercle Bacillus | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium, Glenn Dale, Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09742

Reg. Dist. No. 243

**1. PLACE OF DEATH:**
County: Prince George
City or town: Glenn Dale P. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mo. 12 da.
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 8 mo. 12 da.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 60 G. st., S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

**3. (a) FULL NAME:** YVONNE BROWN

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | colored | single |

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Oct. 30, 1938

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 10 | 21 | ...hrs. ...min. |

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business: —

FATHER
12. Name: William Wright
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Rosie Brown
15. Birthplace: Washington, D.C.

16. Informant: Mother. Rosie Brown
Address: 60 G st., S.W., Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 27 1940 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.

18. Funeral director: John T. Reeves
Address: 904 - 3rd St S.W.

19. Sept. 23 1940 (Date rec'd by registrar) Leo V. O'Meide M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21 1940 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 1940 to Sept. 21 1940 and that I last saw her alive on Sept. 21 1940

| Immediate cause of death | DURATION |
|---|---|
| Tuberculous Menaingitis | 21 days. |
| Due to T.B. Pulmonary Tuberculosis | 10 mo. |
| Due to T.B. | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: Tuberculous Meningitis, Pulmonary Tuberculosis.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed:
Glenn Dale, Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 3 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

09743

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Prince Georges
City or town: Beaver Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Beaver Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5103 Quarles st.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** ELEANOR S. BUGBEE

**3.(b) Social Security Number:** None.

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: John G. Bugbee
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 6, 1849

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 | 5 | 14 | hrs. min. |

9. Birthplace: Pittsburgh, Penna. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home.

FATHER
12. Name: John Brisbane
13. Birthplace: Penna.

MOTHER
14. Maiden name: -?--- Risk
15. Birthplace: Ireland

16. Informant: Mrs. Edith R. Bugbee
Address: 5103 Quarles st. Beaver H'ghts. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 22 1940 (Month) (day) (year)
Cemetery or crematory: Evergreen Cemetery
Location: Bladensburg, Md.
18. Funeral director: F. Garchi Long
Address: Bladensburg Md.

19. 9-21- 1940 (Date rec'd by registrar) By Mrs Monroe Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1940, to Sept 20 1940
and that I last saw h-- alive on Sept. 18 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 2 |
| Arteriosclerosis - | 2 |
| Due to Senility | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert A Harmon M.D.
M. D. or other
Address: 1150 Conn Ave Date signed: 9-20-40
Wash. D.C.

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Prince George
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos.
Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 4 mos

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 356 Maryland ave, N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

**3.(a) FULL NAME:** WALTER BURCH

**3.(b) Social Security Number:** 212-14-2702

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | widowed |

6.(b) Name of husband or wife: Annie Burch
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 7 | 17 | ..... hrs. ..... min. |

9. Birthplace: St Mary's Co, Md.
(Town, county, and state)
10. Usual occupation: Insurance Salesman
11. Industry or business: Insurance.
FATHER 12. Name: Ferdinand E. Burch
13. Birthplace: St. Mary's Co., Md.
MOTHER 14. Maiden name: Sythronia Guy
15. Birthplace: St. Mary's Co., Md.
16. Informant: deceased
Address:
17. Removal to (Burial, cremation, or removal. Which?) Date thereof 9/30/40 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: J. William Lee's Sons Co.
Address: 300 - 4 St N.E. W.D.C.
19. Sept 30 1940 (Date rec'd by registrar) Leo V. Schneider, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 30 1940 at 12 50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1940 to Sept. 30 1940 and that I last saw h.i.m. alive on Sept. 30 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 5 mos. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Sanatorium Date signed: 9/30/40
Glenn Dale, Md.

RECEIVED
OCT 3 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09745

Reg. Dist. No. 230

**1. PLACE OF DEATH:**
County: Prs Georges Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: Baltimore Blvd
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 1 yr.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Prs Geo
City or town: Berwyn Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Baltimore Blvd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: no

**3. (a) FULL NAME:** Emily Burleigh

**3. (b) Social Security Number:** no.

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | widower |

6 (b) Name of husband or wife: H. B. Burleigh
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 25 —

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 — | — | — | hrs. min. |

9. Birthplace: England
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: John Groungeonn
13. Birthplace: England

MOTHER
14. Maiden name: Unknown
15. Birthplace: England

16. Informant: Frederick C Burleigh
Address: 1669 Columbia Rd N.W. Washington DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20 (month) (day) 46 (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington D.C.
18. Funeral director: F Gaeta Sons
Address: Hyattsville Md
19. Sept 19th 1940 (Date rec'd by registrar) John D. Smith Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18, 1940, at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18. 1940, to Sept 18 1940, and that I last saw h— alive on — 19—

| Immediate cause of death | DURATION |
|---|---|
| Acute Cardiac Dilitation | |
| Due to Hypocarditis chr. | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work

23. SIGNATURE: Maybury Riverdale Md.
M. D. or other
Address — Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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RECEIVED
OCT 5 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

09746

## CERTIFICATE OF DEATH

Reg. Diat. No. 243

**1. PLACE OF DEATH:**
County: Prince Georges
City or town: Glen Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 hrs.
Hospital, Institution, or street address where death occurred: Glen Dale Sanatorium
How long in hospital or institution? 14 hrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 918 M St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

**3.(a) FULL NAME:** Charles Carnes

**3.(b) Social Security Number:** 578-05-8392

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Lena Carnes
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): April 17, 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 5 | 1 | ...hrs. ...min. |

9. Birthplace: Charles Co., Md. (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: Motion Picture Distribution
FATHER 12. Name: Wm. E. Carnes
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Dora E. Higgs
15. Birthplace: Charles Co., Md.
16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 20 1940 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington D. C.
18. Funeral director: W. W. Carpenters
Address: 918 Cleveland Ave., Riverdale, Md.
19. Sept 19 40 (Date rec'd by registrar) L. V. Kilmide M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1940 at 5:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17 1940, to Sept 18 1940
and that I last saw h.. alive on Sept 18 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 3 months |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glen Dale Sanatorium Date signed:
Glen Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1702)

09747

# CERTIFICATE OF DEATH

Reg. Dist. No. 231

**1. PLACE OF DEATH:**
County: Prs Georges County
City or town: Defense Highway - Near Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Freemens
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Washington D.C. County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 - 19 st N.E
(If rural, give LOCATION)
2.(a) If veteran, name war: No. ✓

**3.(a) FULL NAME:** Martin Chandler

**3.(b) Social Security Number:** 577-14-5628

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 18, 1918

8. AGE: Years: 22 years | Months: | Days: 23 | If less than one day: hrs. min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: Elevator Operator

11. Industry or business: Ward Medical Bldg 1801 2nd N.W.

FATHER
12. Name: Clinton Chandler
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Polly Williams
15. Birthplace: South Carolina

16. Informant: Clinton Chandler
Address: South Carolina

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 11 1940 (month) (day) (year)
Cemetery or crematory: Stewarts Funeral Co
Location: Washington D.C.

18. Funeral director: Francis Gaeche Sons
Address: Hyattsville Md

19. Sept 11 1940 (Date rec'd by registrar) Mrs Morgan Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1940, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Hemorrhage | |
| Shock | |
| Due to Compound Fracture | |
| of Skull | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 9-11-40
Where did injury occur? Simons Hill Prince Geo (City or town) (County) Md (State)
Injured at home, farm, industry, public place (where?) State road
Means of injury: Automobile turned over Injured at work? No

23. SIGNATURE: James D. Boyd M. D. or other
Address: Forestville Md Date signed: 9-11-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CEIVED
OCT 7 1940
AU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

(94a)

09748

Reg. Dist. No. 245

**1. PLACE OF DEATH:**

County: Pro Geo County

City or town: Chillum Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md County: Pro Geo Co.

City or town: Chillum Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Riggs & Chillum Rds
(If rural, give LOCATION)

2.(a) If veteran, name war: no

**3. (a) FULL NAME:** James A Charles

**3. (b) Social Security Number:** No.

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | widower |

6.(b) Name of husband or wife: Mary E Charles

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): May 25, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 years | 3 | 11 | hrs. min. |

8. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Truck Farmer

11. Industry or business

FATHER
12. Name: Albert Charles
13. Birthplace: England

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs J. E. Gude

Address: Chillum Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9, 1940 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington DC

18. Funeral director: F Gasch's sons

Address: Hyattsville Md

19. Sept 8 1940 (Date rec'd by registrar) Jas Seery Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1940 at 10.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4 1940, to Sept 6 1940 and that I last saw h— alive on Sept 5 1940

Immediate cause of death: Acute Coronary Occlusion

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G. Clertz M.D. M. D. or other

Address: Hyattsville, Md Date signed: 9-6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 5 1940
BUREAU V. S.

09750

# STATE OF MARYLAND—CERTIFICATE OF DEATH

85

**1. PLACE OF DEATH**

County Prince George Registration Dist. No. 231

Village or City Brentwood Md. No. Brentwood Sanatorium St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. 13 How long in U.S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

**2. FULL NAME** Clark, Irene Edsall If U. S. Veteran, specify WAR .....

(a) Residence: No. 1443-B St N.E. St., ..... Ward. .....

(Usual place of abode) If nonresident give city or town and State ✓

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Female | White | Married |

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Ralph Haynes Clark

6. DATE OF BIRTH (month, day, and year) Apr. 2[illegible]-1882

| 7. AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 59 | 4 | 12 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. ✓

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. X

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) Warwick (State or country) New York

FATHER

13. NAME John H. Edsall

14. BIRTHPLACE (city or town) Warwick (State or country) N.Y. Lell

MOTHER

15. MAIDEN NAME Mattie Lell ~~Irene Edsall~~

16. BIRTHPLACE (city or town) ? (State or country) ?

17. INFORMANT Brentwood Hosp. Record (Address) Brentwood, Md.

18. BURIAL, CREMATION, OR REMOVAL Removal Mass. Dr. Place ~~Cedar Hill~~ Date Sept 1, 1940

19. UNDERTAKER J. Wm Lee's Sons Co. (Address) Washington, D.C.

20. FILED Sept 1, 1940 F. Wm Norgle Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** Sept (Month) 1 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 8-18, 1940, to 9-1, 1940

I last saw her alive on 9-1, 1940; death is said to have occurred on the date stated above, at 2:30 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| History of Epilepsy with periodic attacks | 1930 |
| Last attack | 2 weeks ago |
| Heart Failure | Today 9-1-40 |

Other Contributory Causes of importance: none

Name of operation none Date of —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Raymond Foxwell M. D.

(Address) 3916 R.I. Ave Brentwood Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

09751

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

**1. PLACE OF DEATH:** 343 Maryland Ave

County

City or town Hyattsville Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County

City or town Hyattsville Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 343 Maryland Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mrs Nellie P. Cox

**3. (b) Social Security Number** no

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Widow

B (b) Name of husband or wife: George C. Cox

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 12" 1865

**8. AGE:** Years 75 | Months 1 | Days 5 | If less than one day ____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Richard H. Palmer
13. Birthplace: Va

MOTHER
14. Maiden name: Susan Darrell
15. Birthplace: Va

16. Informant: Mrs. Annie Rose

Address: 343 Maryland Ave Hyattsville Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept. 19 1940 (month) (day) (year)

Cemetery or crematory

Location: 2901 - 14 St N.W. Wash. D.C.

18. Funeral director: S. H. Hines Co.

Address: 2901 - 14th St. N.W.

19. Sept. 19" 1940 Mrs Jas. Severe (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1940, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1940 to Sept 19 1940, and that I last saw h[illegible] alive on Sept 16 1940

Immediate cause of death: Myocarditis — DURATION: 2 yrs

Due to

Due to

Other conditions: Hypertension

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. ~~or other~~

Address Hyattsville Md Date signed 9-14-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 5 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09752

13-P

## CERTIFICATE OF DEATH

Reg. Diat. No. 243

**1. PLACE OF DEATH:**

County PRINCE GEORGES

City or town GLENN DALE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mo + 1 day

Hospital, institution, or street address where death occurred:
GLENN DALE SANITORIUM

How long in hospital or institution? 10 mo + 1 day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State D. C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 Congress St. N-E
(If rural, give LOCATION)

2.(a) If veteran, name war √

**3.(a) FULL NAME** GEORGE CUMMINGS

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | colored | Widower |

6.(b) Name of ~~husband or~~ wife unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 12, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 5 | 14 | ..... hrs. ..... min. |

9. Birthplace Greensborough N. Carolina
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business —

FATHER
12. Name Ket Cummings
13. Birthplace Greensborough, N. Carolina

MOTHER
14. Maiden name Celia Caldwell
15. Birthplace Greensborough, N. Carolina

16. Informant Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-27-40 (month) (day) (year)

Cemetery or crematory morgue

Location Washington D. C.

18. Funeral director

Address

19. Sept 27 19 40 Leo V. Schneider M.D. Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 19 40, at 7 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 19 39, to Sept 26 19 40 and that I last saw h~~im~~ alive on Sept 26, 19 40

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 1 year |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D.
M. D. or other

Address Glenn Dale Sanatorium Date signed
Glenn Dale, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09753

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Prince Georges
City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 14 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 First St. S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

**3. (a) FULL NAME:** William Davis

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age —
7. Birth date of deceased (mo., day, yr.): May 12, 1940

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 4 | 12 | hrs. min. |

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: William Smith
FATHER 13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Bertha Davis
MOTHER 15. Birthplace: Columbus, Ga.
16. Informant: Bertha Davis, mother
Address: 607 First St. S.W. Wash. D.C.
17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Sept. 25, 1940 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Joseph's Funeral Home
Address: 1702 - 14th N.W.
19. Sept 25 19 40 (Date rec'd by registrar) L. V. Schneider M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 19 40, at 2 07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 19 40, to Sept 24 19 40 and that I last saw him alive on Sept. 24, 19 40

| Immediate cause of death | DURATION |
|---|---|
| Acute Miliary Tuberculosis | 20 days |
| Due to: Pulmonary Tuberculosis | 2 mos. |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:
Autopsy result: Pulmonary & Miliary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?):
Means of injury — Injured at work? —

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glen Dale Sanatorium Date signed:
Glen Dale, Md.

RECEIVED
OCT 3 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

09979

## CERTIFICATE OF DEATH

Reg. Diat. No. 235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Prince George County

City or town Bradbury Heights, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
4200--Dewey Ave., S. E.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Prince George

City or town Bradbury Heights, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4200--Dewey Ave., S. E.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Howard M. Denison

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

B (b) Name of husband or wife Mabel A. Denison

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 6th, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | | | ____ hrs. ____ min. |

9. Birthplace Forestsville, Md.
(Town, county, and state)

10. Usual occupation Builder

11. Industry or business

FATHER 12. Name John F. Denison

FATHER 13. Birthplace Seat Pleasant, Md.

MOTHER 14. Maiden name Sarah F. Fowler

MOTHER 15. Birthplace Bristle, Md.

16. Informant Mrs. Bertha Brooks

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 5-40 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland, Prs. Geo. Co.

18. Funeral director Thomas F. Murray

Address 2007 Nichols Ave S E

19. Sept 3 1940 (Date rec'd by registrar) L. O. Minear Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 3, 1940, at 7:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1940, to Sept. 3 1940, and that I last saw h[illegible] alive on Sept. 3, 1940

| Immediate cause of death | DURATION |
|---|---|
| Esophageal Hemorrhage | 2 days |
| Due to Esophageal Varocosities | |
| Due to Cirrhosis of Liver - Hypertrophic Stage | 2 mos. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Kuhn M.D. M. D. or other

Address 1716 Lamont St. N.W. Washington, D.C. Date signed 9/3/40

RECEIVED
MAR 22 1941
BUREAU V. S.

Dear Sir;

I Called the registrar who issued the burial permit, and some how the certificate was lost or misplaced. any way they have founded it and will send it to the State Dept Of Health at once, if you should receive my application before you get the certificate from the registrar will you hold it until you get the certificate, and mail me at once a certified of death at once, Thanking you for your correction.

T.F. Murray

Give to ESI

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

## CERTIFICATE OF DEATH

09749

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Prince George's County

City or town: Riverdale, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 814 Cleveland Avenue

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Forty four yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Riverdale Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 814 Cleveland Avenue

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR: none

**3. (a) FULL NAME:** Helen Kerfoot Dodge

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: Joseph A. Dodge Sr.

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 6 | 27 | hrs. min. |

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: none

FATHER — 12. Name: Andrew J. Kerfoot

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Elizabeth Copenhaven

15. Birthplace: Virginia

16. Informant: Mr. Joseph A. Dodge Sr.

Address: 814 Cleveland Ave., Riverdale

17. burial (Burial, cremation, or removal. Which?) Date thereof October 1,1940 (month) (day) (year)

Cemetery or ~~Crematory~~: Glenwood Cemetery

Location: Washington, D. C.

18. Funeral director: W. W. Chambers

Address: 918 Cleveland Ave., Riverdale, Md.

19. Oct 1" 1940 Mrs. Jas. Severe (Date rec'd by registrar) (Registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 27 1940, at 5 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1940, to Sept 27 1940, and that I last saw h alive on Sept 26 1940.

| Immediate cause of death | DURATION |
|---|---|
| Cerebral hemorrhage | 7 hrs |
| Due to | |
| Due to | |
| Other conditions: Hypertension | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Susan Hays M. D. or other

Address: Hyattsville, Md. Date signed 9-28-40

RECEIVED
NOV 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09754

Reg. Dist. No. 243

**1. PLACE OF DEATH:**

County: Prince George

City or town: Glenn Dale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 4 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 4921 Meade St, N. E. (If rural, give LOCATION)

2.(a) If veteran, name war: none

**3. (a) FULL NAME:** Queen Edgerton

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Single |

6.(b) Name of husband or wife: none

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): December 11, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 10 | 19 | ..... hrs. ..... min. |

9. Birthplace: Spartanburg, S. C. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Jake Edgerton
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Frances Whiteside
15. Birthplace: Mills Springs, N. C.

16. Informant: Deceased

Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof 9/30/40 (month) (day) (year)

Cemetery or crematory

Location: Washington, D. C.

18. Funeral director: Malvan & Schey

Address: 424 R St NW

19. Sept 30 1940 (Date rec'd by registrar) Leo V. Kincaide M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 1940, at 1:55 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1940, to Sept 30 1940 and that I last saw her alive on Sept 30 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 10 months |
| Due to | |
| Due to | |
| Other conditions: Syphilis | unknown |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Glenn Dale, Md. Date signed 9/30/1940

RECEIVED
OCT 3 1940
BUREAU V. S.

09755

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

**1. PLACE OF DEATH:**

County: Prince George

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, institution, or street address where death occurred: Sacred Heart Home

How long in hospital or institution? 12 Yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1093 - N. Calvert Ba. Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME** Anna E. Gardiner

**3.(b) Social Security Number** —

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1863

**8. AGE:** Years 77 | Months 6 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Charles Co Md.
(Town, county, and state)

10. Usual occupation: Practical Nurse

11. Industry or business:

FATHER
12. Name: Alfred W. Gardiner
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Gwynn
15. Birthplace: Md.

16. Informant: Deceased.

Address:

17. Burial
(Burial, cremation, or removal, Which?) Date thereof 9-24-40 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Washington D.C.

18. Funeral director: Francis J. Collins

Address: 3821-14th St. N.W. Wash. D.C.

19. Sept 23" 1940 (Date rec'd by registrar) Mrs Jas. Severe Deputy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21 1940 at 5 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1929 to Sept 21 1940 and that I last saw her alive on Sept 20 1940.

| Immediate cause of death | DURATION |
|---|---|
| acute cardiac dilation | 3 days |
| Due to Hypertension | 3-5 years |
| Due to Myocarditis | 1 yr. |
| Other conditions cardio vascular renal disease | 5 yrs. |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thomas E. Mattingly MD M. D. or other

Address: 2200 R. I. ave NE D.C. Date signed 9/21/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1630)

09756

## CERTIFICATE OF DEATH

Reg. Dist. No. 246

**1. PLACE OF DEATH:**

County Prince George

City or town Mt Rainier
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 2800 Ash St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Mt Rainier Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 2800 Ash
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

**3. (a) FULL NAME** Elsie Marie Garrity

**3. (b) Social Security Number** NONE.

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife William Francis Garrity

6(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) June 17, 1892

**8. AGE:** Years 48 Months 3 Days 9 If less than one day ___ hrs. ___ min.

9. Birthplace Munich, Bavaria
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name George Getz
13. Birthplace Bavaria

MOTHER
14. Maiden name Marie Pickle
15. Birthplace Bavaria

16. Informant William Francis Garrity

Address 2800 Ash St. Mt Rainier

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-28-40 (month) (day) (year)

Cemetery or crematory Washington National

Location Suitland Md.

18. Funeral director W. W. Chambers Co

Address Riverdale Md. (918 Cleveland Ave).

19. Sept 28 1940 (Date rec'd by registrar) Harry Valley M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1940, at 2:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death asphyxia

Due to Carbon monoxide poisoning

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 9-26-40

Where did injury occur? Mt Rainier (City or town) Pr. Geo (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury suicide Injured at work no

23. SIGNATURE James H Boyd M.D. or other

Address Forestville Md Date signed 9-26-40

RECEIVED
OCT 7 1940
U. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09757

Reg. Dist. No. 231

**1. PLACE OF DEATH:**
County: Prince Georges (Bladensburg)
City or town: Decatur Heights (Hyattsville) Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred:
4818 Court Street
How long in hospital or Institution? at home

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Pennsylvania County: Blair
City or town: Altoona
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1511 Crawford Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

**3. (a) FULL NAME:** Wilhelmenia Giselle

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: Joseph L. Giselle
6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): July 23, 1873

8. AGE: Years: 67 Months: 1 Days: 29 If less than one day: ..... hrs. ..... min.

9. Birthplace: Wurtemberg, Germany (Town, county, and state)

10. Usual occupation: Invalid

11. Industry or business:

FATHER
12. Name: Mr. J. Teufel
13. Birthplace: Wurtemberg, Germany.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (Germany)

16. Informant: Anthony A. Geisler
Address: 4818 Court St. Hyattsville Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof 9 22 40 (month) (day) (year)

Cemetery or crematory: St. Mary's, Altoona, Pa.
Location:

18. Funeral director: F. Gasch's Sons
Address: 4 Md. Ave. Hyattsville Md.

19. Sept 21 1940 (Date rec'd by registrar) Mrs. Norgle Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-21 1940, at 3 25 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/18 1940, to 9/21 1940 and that I last saw her alive on 9/21 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Apoplexy | 4 days |
| Due to: Arteriosclerosis | 20 yrs |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: George Hageage M.D. M. D. or other

Address: Brentwood, Md. Date signed: 9/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

09758

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163 H)

## CERTIFICATE OF DEATH

Reg. Dist. No. 239

**1. PLACE OF DEATH:**

County Prince George

City or town Laurel WITHIN CORPORATE LIMITS OF

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 207-11th St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 14 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 207-11th St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Emma Mathilda Grimes

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1877

8. AGE: Years 63 Months 5 Days 22 If less than one day hrs. min.

9. Birthplace Baltimore Co. Md (Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business Own Home

FATHER 12. Name Caspar Grimes

13. Birthplace Germany

MOTHER 14. Maiden name Mary Louisa Ellis

15. Birthplace Maryland.

16. Informant John Grimes

Address Laurel Md

17. Burial (Burial, ~~cremation, or removal, which?~~) Date thereof Sept. 8/40 (month) (day) (year)

Cemetery or crematory Salem Lutheran Cemetery

Location Catonsville Md

18. Funeral director Wellfitt Donaldson

Address Laurel Md

19. Sept 8 1940 (Date rec'd by registrar) M. Brashears Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept 5 1940, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death asphyxia

Due to Carbon Monoxide poisoning

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 9-5-40

Where did injury occur? Laurel Prince George Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Closed room and turned injured at work Heavily gas

23. SIGNATURE James T. Boyd M. D. or other

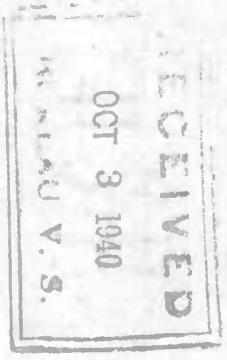
Address Forestville Md Date signed 9-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Salem Lutheran Church.
Bureau - Lancaster



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09759

Reg. Dist. No. 243

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**

County: Prince George

City or town: Glenn Dale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 27 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1 mo. 27 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2115 2nd st., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

**3. (a) FULL NAME:** JOSEPH HENSON

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | colored | widowed |

6.(b) Name of husband or wife: Roberta Edwards

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1886

| 8. AGE: Years | Months | Days | If less than one day: hrs. | min. |
|---|---|---|---|---|
| 54 | 7 | 3 | | |

9. Birthplace: Forestville Md. (Town, county, and state)

10. Usual occupation: mail clerk

11. Industry or business: U. S. Post office

FATHER 12. Name: John Henson

13. Birthplace: Croom, Md.

MOTHER 14. Maiden name: Emma Barnes

15. Birthplace: Croom, Md.

16. Informant: deceased

Address: —

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) 9-29-40

Cemetery or crematory: Woodmont

Location: Washington D. C.

18. Funeral director: Arthur L. Rollins.

Address: 4339 Hunt Pl. NE.

19. Sept 29 1940 (Date rec'd by registrar) Leo V. Domide M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 28 1940, at 11 40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1940, to Sept 28 1940 and that I last saw h...i...m...alive on Sept. 28 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 5 mo. |
| Due to: | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed:

Glenn Dale, Md.

RECEIVED
OCT 3 1940
BUREAU V. S.

09760

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

**1. PLACE OF DEATH:**

County: Prince Georges

City or town: Berwyn Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? approx. 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Alabama County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war: World War - Capt. 76 Field Art.

3. (a) FULL NAME: Claude M. Howard

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: divorced

6.(b) Name of husband or wife: Jennie Morris Howard

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.): About 54 6/28/89.

8. AGE: Years 54 | Months — | Days — | If less than one day — hrs. — min.

9. Birthplace: St Payne, Alabama (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Clerk U.S. Census Bu.

FATHER

12. Name: Milford W Howard

13. Birthplace: Ga

MOTHER

14. Maiden name: Sale Lanford

15. Birthplace: Alabama

16. Informant: Dr. J. Fitzgerald

Address: 439 Maple Lane, Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16, 1940 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington Va

18. Funeral director: F. Gasch & Sons

Address: Hyattsville Md

19. Sept. 15 1940 (Date rec'd by registrar) F. Mae Norgle LOCAL Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1940 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19

and that I last saw h alive on 19

Immediate cause of death: Acute congestive heart failure

Due to: Myocardosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James I. Boyd M. D. or other

Address: Forestville Md Date signed: 9-14-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 28 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7)

09761

# CERTIFICATE OF DEATH

Reg. Dist. No. 239

**1. PLACE OF DEATH:**

County Prince George

City or town Laurel, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 317 - 2nd St.,

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Pfince George

City or town Laurel Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 317 - 2nd St.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

**3. (a) FULL NAME** Lewis Minor Innerarity

**3. (b) Social Security Number** None

4. Sex: Male

5. Color or race: White

8. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Emily Toms Inerarity

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1856

**8. AGE:** Years 84 | Months 6 | Days 4 | If less than one day ____ hrs. ____ min.

9. Birthplace Birmingham, Ala.
(Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business Moving Picture Industury

FATHER
12. Name James Innerarity
13. Birthplace Scotland

MOTHER
14. Maiden name Frances Weymes
15. Birthplace Scotland

16. Informant Mrs. John H. Cutler

Address 317 - 2nd St. Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 21, 1940 (month) (day) (year)

Cemetery or cremafory Greenmount Cem'ty

Location Baltimore, Md.

18. Funeral director Wellett Donaldson

Address Laurel, Md.

19. Sept 21 1940 (Date rec'd by registrar) M. Beasheare Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1940 19____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 8 1940, to 9 19 1940, and that I last saw him alive on 9 19 1940.

Immediate cause of death Carcinoma Lung

Due to Bronchopneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 68.40 / 9.17.40

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE B. Rikerson M. D. or other

Address Laurel Date signed 9.20.40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

09762

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

**1. PLACE OF DEATH:**

County: Prince Georges

City or town: Glenn Dale Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 1 yr. 1 mos/6 day

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 655 Morton ST. N.W. (If rural, give LOCATION)

2.(a) If veteran, name war: no ✓

**3.(a) FULL NAME:** Albert Jones

**3.(b) Social Security Number:** none

4. Sex: male

5. Color or race: colored

6.(a) Single, married, widowed, or divorced: separated

6.(b) Name of husband or wife: Edna Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 18, 1898

**8. AGE:** Years: 41 Months: 11 Days: 24 If less than one day ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER
12. Name: Alex Jones
13. Birthplace: Va

MOTHER
14. Maiden name: Elsie French
15. Birthplace: Sperryville Va

16. Informant: Deceased

Address: 655 - Morton ST. N.W.

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: 9/13/40 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: William T. Moten

Address: C 1702 12th N.W.

19. 9/13 19 40 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12th 1940, at 2.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26th 1939, to Sept 12th 1940 and that I last saw him alive on Sept 12th 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 1 yr. 8 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed

Glenn Dale, Md.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (13C)

09763

# CERTIFICATE OF DEATH

Reg. Dist. No. 243

**1. PLACE OF DEATH:**
County: Prince George
City or town: Glenn Dale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 7 mos. 11 day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1513 Carroline St N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: no ✓

**3.(a) FULL NAME:** Bernice Jones

**3.(b) Social Security Number:** None

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: Single
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 6th 1911

**8. AGE:** Years: 29 Months: 5 Days: 22 If less than one day ..... hrs. ..... min.

9. Birthplace: Wash. D.C. (Town, county, and state)
10. Usual occupation: Maid
11. Industry or business:
FATHER
12. Name: Ernest Jones
13. Birthplace: Virginia
MOTHER
14. Maiden name: Beulah Williams
15. Birthplace: Virginia
16. Informant: Deceased
Address: 1513 Carroline St N.W. Wash DC
17. Removal (Burial, cremation, or removal. Which?) Date thereof: 9-29-40 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Washington, D.C.
18. Funeral director: L. E. Murray & Son
Address: 2105 - 12th st N.W.
19. Sept 29 1940 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28th 1940, at 12:15 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feby 17th 1940, to Sept 28th 1940 and that I last saw her alive on Sept 28th 1940
Immediate cause of death: Pulmonary Tuberculosis — DURATION: 7 mos
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Glenn Dale, Md. Date signed: 9/28/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1940
BUREAU V. S.

09764

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-C

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

**1. PLACE OF DEATH:**

County Prince Georges

City or town Glenn Dale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mos

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 10 mos.

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State D.C. County

City or town Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 1419 First St. N.W. (If rural, give LOCATION)

2.(a) If veteran, name war —

**3. (a) FULL NAME** William Lucas

**3. (b) Social Security Number** 579-05-5444

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Separated

6.(b) Name of husband or wife: Alice Lucas

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.): March 29, 1906

**8. AGE:** Years 34 | Months 5 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Pittsburgh, Pa. (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

FATHER 12. Name Lazous Moore

13. Birthplace Pittsburgh Pa.

MOTHER 14. Maiden name Esther Porter

15. Birthplace Caroline, Va

16. Informant Deceased

Address 1419 First St. N.W. Wash. D.C.

17. Removal to (Burial, cremation, or removal. Which?) Date thereof Sept. 24, 1940 (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director Malvan & Schey

Address 424 R St. N.W.

19. 9/24 1940 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1940, at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 25, 1939, to Sept. 24 1940 and that I last saw him alive on Sept. 24, 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION 2 yrs.

Due to

Due to

Other conditions: Bullous Emphysema — 10 mos.

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results Pul. Tuberculosis + Emphysema

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) — —

Means of injury — Injured at work? —

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other

Address Glenn Dale Sanatorium Date signed

Glenn Dale, Md.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1940
BUREAU V. S.

09765

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (114d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

**1. PLACE OF DEATH:**

County: Prince Georges

City or town: Glenn Dale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 19 days.

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 2 mos. 19 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 100 Eye St. N.W. (If rural, give LOCATION)

2.(a) If veteran, name war: none ✓

**3.(a) FULL NAME:** Alonzo Maynard

**3.(b) Social Security Number:** 578-03-7355

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Separated

6.(b) Name of husband or wife: Bertha Maynard

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): April 23, 1896

**8. AGE:** Years: 44 Months: 4 Days: 23 If less than one day: ..... hrs. ..... min.

9. Birthplace: Calvert Co., Maryland (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: Truck driver

FATHER
12. Name: Wm Maynard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Watkins
15. Birthplace: Maryland

16. Informant: Deceased

Address: 100 Eye St. N.W. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 16, 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: John J Stewart

Address: 30 H st N E / Wash. D.C.

19. Sept 16th 1940 (Date rec'd by registrar) Le V. Schneider M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16 1940, at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1940, to Sept. 16 1940 and that I last saw him alive on Sept. 16 1940

Immediate cause of death: Pulmonary Abscess (Non Tuberculous)

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

DURATION: 9 mos from history

Major findings of operations: —

— Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed:

Glenn Dale Md

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 3 1940
BUREAU V. S.

09766

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c)

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

**1. PLACE OF DEATH:**
County Pro Geo County
City or town Riverdale Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Baltimore Blvd
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 16 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Pro Geo Co.
City or town E. Riverdale Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 18 Stevens Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

**3. (a) FULL NAME** Henry George Menke

**3. (b) Social Security Number** no.

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Lucy Virginia Menke
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 20,

**8. AGE:** Years 60 | Months — | Days — | If less than one day ___ hrs. ___ min.

9. Birthplace Holland (Town, county, and state)
10. Usual occupation Engineer
11. Industry or business University of Md.

FATHER
12. Name Geo Menke
13. Birthplace Germany

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Edith V. Talbott (Daughter)
Address 18 Stevens Ave - E. Riverdale Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 16, 1940 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Washington D C

18. Funeral director F. Gasch's sons
Address Hyattsville Md.

19. Sept 1. 1940 (Date rec'd by registrar) F Wm Norgle LOCAL Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14, 1940, at 1:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Hemorrhage Shock
Due to Crushed Chest
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9-14-40
Where did injury occur? Riverdale Pr Co Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route #1
Means of injury Auto mobile Collision Injured at work? no

23. SIGNATURE James H Boyd M. D. or other
Address Forestville Md Date signed 9-14-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

09767

## CERTIFICATE OF DEATH

Reg. Dist. No. 2.40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Prince Geo Co
City or town: Brandywine md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Prince Geo Co
City or town: Brandywine md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Mary Rose Oregon Owen

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Wid |

6.(b) Name of husband or wife: Thomas J. Owen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mch 17—1850

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 90 | 6 | 17 | ..... hrs. ..... min. |

9. Birthplace: Charles Co Md
(Town, county, and state)

10. Usual occupation: Home work

11. Industry or business

FATHER
12. Name: William H. Welch
13. Birthplace: Chas Co md

MOTHER
14. Maiden name: Mary Jane Francein
15. Birthplace: Chas Co md

16. Informant: Mrs Brent Early
Address: Brandywine md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3 1940 (month) (day) (year)
Cemetery or crematory: St Ignatious
Location: Bealton Md

18. Funeral director: Hunt & Ryon
Address: Waldorf Md

19. Oct 1 1940 (Date rec'd by registrar) F. H. Billingsley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/30 1940, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/15 1938, to 9/30 1940
and that I last saw h.e.r alive on 9/30 1940

Immediate cause of death: Cardio-vascular Renal disease

Due to: Senility

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

| DURATION |
|---|
| |
| |
| |
| |
| |
| |
| |

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. S. Wallace M.D.
M. D. or other
Address: Waldorf, Md Date signed: 10/1/40

RECEIVED
NOV 2 1940
U. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09768

Reg. Diat. No. 243

**1. PLACE OF DEATH:**

County: Prince Georgia County

City or town: Glenn Dale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 9 months

Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 3 yrs., 9 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: District of County: Columbia

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1002 Irving St, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** Gladys Pinckney

**3.(b) Social Security Number:** NONE

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | married |

6.(b) Name of husband or wife: John Pinckney

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): May 16, 1914

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 26 | 4 | 24 | ....hrs. ....min. |

9. Birthplace: Revere, Pa. (Town, county, and state)

10. Usual occupation: maid

11. Industry or business: Domestic work

FATHER

12. Name: Irskine Turner

13. Birthplace: Staunton, Va

MOTHER

14. Maiden name: Alberta Smith

15. Birthplace: Lynchburg, Va.

16. Informant: Deceased

Address

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) Sept (day) 10 (year) 1940

Cemetery or crematory

Location: Washington D-C

18. Funeral director: Willis F. Hunter

Address: 2503 Nichols ave

19. (Date rec'd by registrar) Sept 10 1940 Registrar: Leo V. Altmeide M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 1940, at 7½ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11, 1937, to Sept. 9 1940

and that I last saw h.e.r. alive on September 9 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 3 years, 9 months |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results: Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163) D

09769

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

**1. PLACE OF DEATH:**

County Prince Georges

City or town Fairmont Height (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 105 White Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6 weeks

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Fairmont Heights Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 105 White Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Evelyn Theressa Poteat

3. (b) Social Security Number

4. Sex F

5. Color or race C

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George Poteat

6(c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1919

8. AGE: Years 21 Months 24 Days 0 25 If less than one day ___ hrs. ___ min.

9. Birthplace Louiseville Ky (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Freddie De Botts

13. Birthplace Washington D.C.

MOTHER 14. Maiden name Lucille Beasley

15. Birthplace Nashville Tenn

16. Informant Timothy Harrison

Address 1436 Swann St Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 5 1940 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Wash. D.C.

18. Funeral director Robert T. McGuire

Address 1820 - 9th St. N.W. Wash D.C.

19. 9-2 — 1940 Rene A. Bonner (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1940, at 12 30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Shock

Due to acute bichloride of mercury poisoning

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 9-2-40

Where did injury occur? Fairmont Hts (City or town) Pizes (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Took bichloride tablets Injured at work? no

23. SIGNATURE James J. Boyd M. D., or other

Address Westville Md Date signed 9-2-40

RECEIVED
OCT 4 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

# CERTIFICATE OF DEATH

09778

Reg. Dist. No. 235

**1. PLACE OF DEATH:**
County Prince Georges Co.
City or town Bradbury Hts.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution 4708 Shadyside Ave
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 39 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Pr. Geo.
City or town Bradbury Hts Ward No. —
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 4708 Shadyside Ave, Brad. Hts.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** Sarah A Powell

**3. (b) Social Security Number** ?

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Paul A. Powell

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 5 1872

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 3 | 14 | — hrs. — min. |

9. Birthplace Millstone, Maryland (Town, county, and state)

10. Usual occupation Home Keeping

11. Industry or business Home work

FATHER
12. Name Eli Brown
13. Birthplace ?

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Paul A. Powell
Address 4704 Bradbury Hts Md Shadyside Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-23-40 (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington Va.

18. Funeral director Geo W Mac Gunn
Address 2900 M st NW D.C.

19. 9-19 1940 L.O Minear
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1940, at 7:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch. 10 1940, to 9-19 1940, and that I last saw h— alive on 9-19 1940.

| | DURATION |
|---|---|
| Immediate cause of death Coronary Occlusion | ? |
| Due to Arteriosclerosis | |
| Due to — | |
| Other conditions Chronic Interstitial Nephritis | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations ?
Of autopsy ?

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Arthur N. Meloy M.D. or other
Address 4400 Bowen Rd Date signed 9-19-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

# CERTIFICATE OF DEATH

6977L

Reg. Dist. No. 235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Prince George
City or town Silver Hill
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 weeks

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State District of Columbia County
City or town Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 420 - 6th St NW,
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR N

**3. (a) FULL NAME** Ella E. Sanderson

**3. (b) Social Security Number** 578-10-3136

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife William Sanderson
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 1880

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 7 | 9 | hrs. min. |

9. Birthplace Forestville Md (Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business
FATHER 12. Name Richard Selby
13. Birthplace England
MOTHER 14. Maiden name Caroline Soper
15. Birthplace Cheltenham Md
16. Informant Mrs John B Elliott
Address Silver Hill Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-20-40 (month) (day) (year)
Cemetery or crematory
Location Washington D C.
18. Funeral director W W Chambers Co
Address 417-11 St S.E.
19. 19-20 1940 (Date rec'd by registrar) L O Minear Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1940, at 8:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19

| Immediate cause of death | DURATION |
|---|---|
| Acute Congestive heart failure | |
| Due to Cardio Vascular renal disease | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James J. Boyd M. D. or other
Address Forestville Md Date signed 9-20-40

RECEIVED
SEP 27 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09772

Reg. Dist. No. 243

**1. PLACE OF DEATH:**
County: Prince George
City or town: Glenn Dale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 month
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3405 Sherman Ave, N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

**3. (a) FULL NAME:** Curtis Smith

**3. (b) Social Security Number:** None 578-81-0636

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Single |

6.(b) Name of husband or wife: none
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 10, 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 27 | 7 | 19 | ..... hrs. ..... min. |

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Wesley Smith
13. Birthplace: South Carolina
MOTHER 14. Maiden name: Dora Wright
15. Birthplace: South Carolina
16. Informant: Deceased
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-29-40 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D. C.
18. Funeral director: Rives Bros.
Address: 1433 New York Ave. N.W.
19. Sept 29 1940 Leo V. McBride M.D. Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 1940, at 12 05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 25, 1940, to Sept 29 1940
and that I last saw h.. alive on Sept 29 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 6 months |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed 9/29/40
Glenn Dale Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 3 19[illegible]
BUREAU [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09773

Reg. Dist. No. 243

**1. PLACE OF DEATH:**

County: Prince George

City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium 14 days

How long in hospital or institution? 14 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 730 Gresham Pl. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

**3.(a) FULL NAME:** David A. Staton

**3.(b) Social Security Number:** 578-03-4838

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6.(b) Name of husband or wife: Sayress Staton

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): June 22, 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 25 | 2 | 26 | hrs. min. |

9. Birthplace: Edgecome County, N.C.
(Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: Washington Hotel

FATHER
12. Name: Willie Staton
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Whitfield
15. Birthplace: North Carolina

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept 18 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: James M. Miller

Address: 2256 - 12th St N.W.

19. Sept 18 1940 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1940 at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4 1940, to Sept 18 1940 and that I last saw him alive on Sept. 18 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 10 months |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

69774

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: PRINCE GEORGES
City or town: GLENN DALE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Mon. 9 days
Hospital, institution, or street address where death occurred:
GLENN DALE SANATORIUM
How long in hospital or institution? 3 Mon. 9 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5759 - 13th st., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: √

**3. (a) FULL NAME:** GATE TAYLOR

**3. (b) Social Security Number:** 578-07-6685

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | married |

6.(b) Name of husband or wife: Diana Taylor
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Mar. 23, 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 5 | 13 | hrs. min. |

9. Birthplace: Chicago Ill. (town, county, and state)
10. Usual occupation: advertising manager
11. Industry or business: advertising
FATHER 12. Name: A. R. Taylor
FATHER 13. Birthplace: Danville, Ill.
MOTHER 14. Maiden name: Rachel Miller
MOTHER 15. Birthplace: Brazil, Ind.
18. Informant: deceased
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof: Sept 5, 1940 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.
18. Funeral director: S. H. Hines Co.
Address: 2901 - 14th St. N.W.
19. Sept. 5 1940 (Date rec'd by registrar) Leo V. Kilmeade M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5, 1940, at 1 30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1940, to Sept 5 1940 and that I last saw h.im alive on Sept. 5 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | 1931 |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: n.d.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed
Glenn Dale, md.

RECEIVED
OCT 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a) AB

09775

# CERTIFICATE OF DEATH

Reg. Dist. No. 235

**1. PLACE OF DEATH:**
County Pro Geo Co.,
City or town upper Marlboro Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) 2 weeks
Stay in this community (yrs., or mos., or days) Trable

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State ~~Md~~ County ~~Pro Geo Co~~
City or town washington DC Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3628-18th st N.E.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

**3. (a) FULL NAME** Rose Weber

**3. (b) Social Security Number** no.

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife R. L. Weber
obt
6(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: (about 72)

| Years | Months | Days | It less than one day |
|---|---|---|---|
| | / | / | / hrs. / min. |

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace " ~~Maryland~~ ?

MOTHER
14. Maiden name Mary
15. Birthplace unknown

16. Informant Mr. R. L. Weber
Address 3628-18th st N.E

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Sept 18/40
(month) (day) (year)
Cemetery or crematory Forth Lincoln
Location Cottage City Md

18. Funeral director F. Gasch's Sons
Address Bladensburg Md

19. 9-16- 1940 Thos. D. Griffith
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15/40 19 , at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death acute congestive heart failure
Due to Cardio vascular renal disease
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James I. Boyd M.D. or other
Address Forestville Md Date signed 9-16-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09776

Reg. Dist. No. 240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH**

County: Prince Georges

City or town: Brandywine (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): One year

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Croom Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mary Lea Redding

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife: Emory Redding

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unk.

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | | | hrs. min. |

9. Birthplace: Brandywine Md (Town, county, and state)

10. Usual occupation: Domestics

11. Industry or business

FATHER 12. Name: Wm O Tayman

FATHER 13. Birthplace: Pascataway Md

MOTHER 14. Maiden name: Sarah King

MOTHER 15. Birthplace: Pascataway Md

16. Informant: John Taymin

Address: Brandywine Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21, 1940 (month) (day) (year)

Cemetery or crematory: Rosaryville Cemetery

Location: Rosaryville Md

18. Funeral director: Ritchie Brothers

Address: Upper Marlboro, Md

19. Sept 20 1940 (Date rec'd by registrar) F H Billingsley Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 31 1940, to Sept 19 1940 and that I last saw h[illegible] alive on Sept 13 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Throat | 1 Year |
| Due to | |
| Due to | |
| Other conditions: Mitral regurgitation | 3 yrs |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of Injury: Injured at work?

23. SIGNATURE: John E. Bowers M. D. or other

Address: Brandywine Md Date signed: Sept 20/40

RECEIVED
OCT 3 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09772 42

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Prince George
City or town: Fairmount Heights, Md (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 5906 - Iowa ave
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 7 yrs 4 mo., 7 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Fairmount Heights Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. 5906 - Iowa ave. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Benjamin Wedge

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife: Julia Waters Wedge
6(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): Oct. 8, 1888

8. AGE: Years: 52 | Months: 11 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Queen Anne Co., Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Dist. Col Govt.

FATHER
12. Name: George W. Wedge
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Wallace
15. Birthplace: Maryland

16. Informant: Julia Wedge
Address: Fairmount Hts Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-16-40 (month) (day) (year)
Cemetery or crematory: Local
Location: Upper Marlboro, P.G. Co

18. Funeral director: [illegible]
Address: [illegible]

19. Sept. 14 1940 Irene A. Conner
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12 1940, at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11 1940 to Sept. 12 1940, and that I last saw him alive on Sept. 12 1940

| Immediate cause of death | DURATION |
|---|---|
| Acute Nephritis | 3 weeks |
| Due to Catarrhal Jaundice acute | 1 mo. |
| Due to Myocardial damage | 1 week |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harrison C. Belden M. D.
Address: Fairmount Heights Md Date signed 9-12-40

RECEIVED
OCT 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

# CERTIFICATE OF DEATH

09778

Reg. Dist. No. 276

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

**1. PLACE OF DEATH:**

County: Prince George.

City or town: Brentwood (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 3 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Brentwood Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 4451 - Holladay St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Lawrence J. Whalen

**3. (b) Social Security Number:** 217-03-7592

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | widowed |

6 (b) Name of husband or wife: Elizabeth Theresa Whalen

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 10 | | hrs. min. |

9. Birthplace: Hartford County. (Town, county, and state)

10. Usual occupation: retired Contractor

11. Industry or business

FATHER — 12. Name: Thomas Whalen

FATHER — 13. Birthplace: Philadelphia Pa.

MOTHER — 14. Maiden name: Johanna Doyle

MOTHER — 15. Birthplace: Philadelphia Pa.

16. Informant: Lawrence Whalen Son.

Address: 4451 - Holladay St. Brentwood

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 9-30-40 (month) (day) (year)

Cemetery or crematory: St. Stephens Church Cemetery

Location: Bradshaw, Baltimore County Md

18. Funeral director: Wm. J. Malley.

Address: 3200 - Rhode Island Ave. Mt. Rainier.

19. Sept 28 19 40 (Date rec'd by registrar) Hyattsville, Md. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1940, at 9.25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26 1940, to Sept. 26 1940, and that I last saw him alive on Sept. 26 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Acute Dilatation of Heart | 10 minutes |
| Due to | |
| Due to | |
| Other conditions: Diabetes | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN** — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles C. Hageage M. D. (M. D. or other)

Address: Mt. Rainier, Md. Date signed 9/27/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

09779

**1. PLACE OF DEATH** (83a)

County Prince Georges Registration Dist. No. 233

Village or City Croom Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** John F. Wilson If U. S. Veteran, specify WAR

(a) Residence: No. Croom Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa E Wilson

6. DATE OF BIRTH (month, day, and year): Dec 7 1861

7. AGE: Z Years: 79 Months: 9 Days: 5 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Plasterer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year): 1935

11. Total time (years) spent in this occupation: life

12. BIRTHPLACE (city or town) (State or country): Princes Georges Co. Md

FATHER

13. NAME: Aquilla Wilson

14. BIRTHPLACE (city or town) (State or country): Croom Md

MOTHER

15. MAIDEN NAME: Rosa Hutchison

16. BIRTHPLACE (city or town) (State or country): Baltimore Md

17. INFORMANT (Address): Mary Wilson Croom Md

18. BURIAL, ~~CREMATION, OR REMOVAL~~: Upper Marlboro, Md Date 9/14, 1940

19. UNDERTAKER (Address): Ritchie Brothers Upper Marlboro Md

20. FILED Sep 12 1940 James B Taylor Deputy Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** Sep. (Month) 12 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Sep 12, 1940, to , 19

I last saw h elive on , 19 ; deeth is said to have occurred on the date stated above, at 7:30 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Dead when I reached him | |
| Cerebral Hemorrhage | Sep 12/40 |
| Other Contributory Causes of importance: | |
| Arterio-Sclerosis | 1930 |

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John E Bowers M.D.

(Address) Brandywine Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

RECEIVED
OCT 8 1928
BUREAU V. S.

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-C)

09780

## CERTIFICATE OF DEATH

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Pr. Geo Co.
City or town: Largo
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Landover Md R.F.D.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 1

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland. County: Pr. Ges.
City or town: Largo Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Landover Md RFD.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Howard Windsor

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | single |

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 16 1940

**8. AGE:** Years | Months | Days | If less than one day: 6 hrs. 30 min.

8. Birthplace: Largo Pr Geo Co. Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: John Everette Windsor
13. Birthplace: Largo Md

MOTHER
14. Maiden name: Clara Estelle Ferguson
15. Birthplace: Largo Md.

16. Informant: Mrs. Everette Windsor
Address: Landover Md R.2.0.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 17 1940 (month) (day) (year)

Cemetery or crematory:
Location: Forestville Md
18. Funeral director: Ritchie Bros
Address: Upper Marlboro Md

19. Sept 17 1940 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 17 1940, at 2:00 A M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Sept 16 1940, to Sept 17 1940, and that I last saw h in alive on Sept 16 1940.

Immediate cause of death: Prematurity — DURATION: 6 1/2 hours.

Due to: Placenta Praevia

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Suit Ritchie M.D.
M. D. or other
Address: Rte 1 Benning Sta DC Date signed: Sept 17 1940

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OCT 5 1940
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